CYPRESS CLINIC
MEDICAL QUESTIONNAIRE

DATE _____

NAME _____ DATE OF BIRTH _____ AGE _____ SEX _____

MARITAL STATUS _____ NUMBER OF CHILDREN _____ OCCUPATION _____

Past Medical/Surgical History

Description	Description	Description

REGULAR MEDICATION (Include Prescription, Over-the-Counter, Vitamins, Birth Control Pills, etc.)

ALLERGIES TO MEDICATIONS _____ _____ _____

OTHER ALLERGIES _____ _____ _____ _____

Family History/Medical Problems (Include High Blood Pressure, Heart Attack, Stroke, Diabetes, Cancer, Tuberculosis, Glaucoma, Thyroid, etc.)

MOTHER _____

FATHER _____

BROTHERS _____

SISTERS _____

CHILDREN _____

Social History

Cigarettes:_____ packs/day for _____ years. Quit? _____

Alcoholic drinks: _____ drinks per _____ week or drinks per _____ Quit? _____

Coffee: _____ cups/day; soda/tea: _____ glasses/day

Difficulty sleeping? Falling asleep _____ staying asleep _____ early awakenings _____

How often do these problems with sleep occur? _____

Exercise type: _____

Hobbies: _____